

This is the abstract of a study selected by Drug and Alcohol Findings as particularly relevant to improving outcomes from drug or alcohol interventions in the United Kingdom. It was not published by Drug and Alcohol Findings. Unless permission has been granted, we are unable to supply full text. Click on the [Title](#) to visit the publisher's or other document supplier's web site. Other links to source documents also in blue. Hover mouse over orange text for explanatory notes. Free reprints may be available from the authors - click [Request reprint](#) to send or adapt the pre-prepared e-mail message. The abstract is intended to summarise the findings and views expressed in the study. Below are some comments from Drug and Alcohol Findings.

Click [HERE](#) and enter e-mail address to be alerted to new studies and reviews

► **"I inject less as I have easier access to pipes": injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed.**

Leonard L., DeRubeis E., Pelude L. et al. [Request reprint](#)

International Journal of Drug Policy: 2008, 19(3), p. 255–264.

After needle exchanges started distributing crack smoking equipment, drug injectors in Ottawa shifted from injecting to smoking the drug and less often shared their smoking equipment. The result was safer drug use and greater service contact by crack smokers.

Abstract Among drug injectors in Ottawa, the prevalence of HIV (21%) and of hepatitis C (76%) infection are among the highest in Canada. Recent research suggests the potential for both viruses to be transmitted through the multi-person use of crack-smoking implements. On the basis of this evidence, in April 2005 Ottawa's needle exchange programme started distributing these implements and associated items to reduce the harms associated with smoking crack. Items distributed included: glass stems; rubber mouthpieces; brass screens; chopsticks; lip balm; chewing gum; and written material emphasising non-sharing behaviour and safe disposal. There was no restriction on the amount of equipment which could be collected; implements were distributed in the quantities requested by the users. Items in the crack kits were also available individually in the quantities requested.

This study aimed to evaluate the impact of this initiative on a variety of practices which risk viral transmission. Via street-based outreach, it recruited people who had injected drugs in the past six months who consented to personal interviews and provided saliva for hepatitis C and HIV testing. Injectors were sampled at four time points: six months before distribution started; and one, six and 12 months after it had started. From among the sampled injectors, the study focused on those (500 out of 634) who also reported having smoked crack in the past six months. Sample sizes ranged from 114 to 167 people; the same injectors might be sampled at several time points. Most had recently lived in unstable housing. Saliva tests indicated that over half were infected with hepatitis C. Apart from cannabis and alcohol, cocaine was the most widely used drug and it was also the most widely injected.

At all the time points about 90% of the participants were using needle exchanges in

Ottawa. Within a month, 80% had taken up the offer of crack-smoking implements from the exchanges, rising to 87% after 12 months, at first generally in the form of complete kits, later individual items. Accounting for people who received exchange equipment via other users, access to crack-smoking equipment became virtually universal.

By definition, all the participants had injected in the past six months, but more recent injecting significantly declined after distribution started. 96% of the pre-implementation sample reported injecting in the past month compared to 84% one month after distribution started and 78% after six and 12 months. Six and 12 months post-implementation, people who had directly or indirectly received fresh crack-smoking equipment from the exchanges (the great majority of the samples) were asked about changes in their drug use practices since the equipment became available. At both time points, about 4 in 10 said they injected less often (very few said more often), and the third most commonly cited reason was the new service. At the same time points, about a quarter (25% and 29% respectively) of participants said they now smoked crack more frequently, and about 1 in 10 less frequently. At six months advent of the new service was the most common explanation offered. Together these statistics represent a shift to a less harmful way of consuming the drug (ie, from injecting to smoking).

Infection-related risks associated with crack smoking were also reduced. Following the start of the new service, the proportion (80% or more) who in the past six months had shared non-injecting drug consumption equipment remained stable, but among these respondents there was a statistically significant decline in the frequency of sharing: the proportion sharing 'every time' fell from 37% in the six months before implementation, to 31% one month after, and 12% and 13% respectively six and 12-months post-implementation.

The authors observed that uptake of the initiative by Ottawa's injectors/crack smokers was immediate, high and sustained, demonstrating a high level of unmet need for such resources, and that this uptake was accompanied by transitions to safer drug use methods and practices less likely to spread disease. Given this finding, they argued that other needle exchanges should adopt this practice.

FINDINGS

Impact of the initiative in terms of transitioning from injecting to smoking might have been greater had cocaine powder (not suitable for smoking) been less dominant and crack (suitable for smoking) more common. On the other hand, the very high proportion of sampled injectors who used the exchanges must have created an extensive platform for the distribution of crack-smoking equipment to affect drug use practices in the city. Where exchange use is less widespread, the impact across an area would probably be less apparent, even if exchange users themselves reacted as intended. However, [as it did in both Ottawa and Toronto](#), providing such equipment can itself extend exchange usage, exposing new drug users to harm reduction assistance and a route to treatment interventions. It may also attract users to exchanges earlier in their drug using careers when they have yet to fully (or at all) embrace injecting; hepatitis C is commonly contracted rapidly after injecting commences, so early contact is vital.

The main queries over the study arise from the absence of a control site without access to crack smoking equipment from the exchanges. Without this benchmark, it is impossible to be sure that the initiative was responsible for the changes in drug use practices. For example, 12 months after implementation, increased availability of crack

was the most common reason given for smoking the drug more often, and reduced injecting was most often attributed to a desire to stop injecting and a preference for smoking. However, even in these cases it seems likely that advent of the new service enabled more people to realise these desires and plans, and to use the newly available crack supplies more safely. Whether these changes were extensive enough to seriously dent transmission of the highly transmissible hepatitis C virus seems questionable, though the chance that that they might, and the potential for other benefits, may be seen as justifying the effort.

England has [about 200,000 crack users](#) who potentially might benefit from services of the kind researched by the study. Such services are partly justified by concern over possible [spread of infection](#) due to sharing equipment used to smoke the drug, though the reality of the risk is not yet securely confirmed. Just as or perhaps more important is the role provision of equipment might play in converting injectors to (or at least, towards) non-injecting drug use.

Trying to convert crack/cocaine injectors to smokers or sniffers is important not just in terms of preventing the immediate complications of injecting, but also because crack/cocaine injecting [heightens the risk](#) of disease transmission. One reason is the frequency of injecting due to the short-lived nature of the drug's effects, making it hard for exchanges [in Britain](#) and elsewhere to match supply to need. The spread of crack injecting has [probably contributed](#) to the rapid transmission of the hepatitis C virus in Britain and the continuing spread of HIV. In [2006 in England](#), nearly three-quarters of the customers of pharmacy-based needle exchanges used crack, an indication of the potential scope for crack-focused harm reduction initiatives. Another is the fact that a third of injectors [sampled at British drug services in 2007](#) said they injected crack, and crack or cocaine injectors were more likely to have recently shared injecting equipment, to have suffered injecting site damage, and to have been infected with hepatitis C.

Indications that distributing non-injecting drug use equipment in Britain might result in some of the benefits suggested by the study come from a [pilot project](#) at four needle exchange programmes in south west England in 2006 and 2007. During the study the exchanges offered foil packs to service users. Just over half the opiate users among them took up the offer, which also provided an opportunity to discuss the risks of injecting and transition to non-injecting. While foil was available, service visits increased by a third and new visitors attended the services who chased heroin but did not inject. At one of the exchanges surveys revealed that all but two people who took foil reported using it, and that as a result, 85% reported smoking their drugs when they would otherwise have injected.

Despite these indicators of need and potential benefit, [UK law](#) makes it an offence to supply equipment to be used for smoking crack or foil for smoking heroin, leaving needle exchanges in the perverse situation of being able to supply equipment to make the most dangerous method of drug use (injecting) somewhat less risky, but unable to supply equipment which might support transition to a far less dangerous method (smoking). The result is to limit their capacity to fulfil their harm reduction role. It was perhaps this legal barrier which led the UK's National Institute for Health and Clinical Excellence (NICE) [to recommend](#) that needle exchanges "encourage [their users] to ... switch to non-injecting methods", but not to advocate the distribution of equipment to facilitate this transition.

Consulted on the guidance, people working with needle exchange programmes were disappointed with this omission. Their comments were in line with the results of a [survey](#) conducted in 2008 of UK needle exchange workers. Due mainly to the law, just 15% of the 445 respondents said their services distributed foil, but most supported its provision as a useful harm reduction intervention for both heroin and crack cocaine users. Attempts are [currently being made](#) to remove or amend the legal restrictions in the UK. In [North America](#), where in recent years crack use has been the major illicit drug problem, a response including distribution of crack kits has been common if sometimes controversial.

As foreshadowed in the featured report, despite public health support, in July 2007 the city council headed by a newly elected major, who wished to restrict needle exchange in general, cancelled Ottawa's safer crack use initiative. However, provincial funding has [enabled the programme to continue](#) at another site.

Thanks for their comments on this entry in draft to Jamie Bridge of the [International Harm Reduction Association](#) and the [UK National Needle Exchange Forum](#). Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 15 June 2009

► [Comment on this entry](#) ► [Give us your feedback on the site \(one-minute survey\)](#)

Unable to obtain the document from the suggested source? Here's an [alternative](#).

Top 10 most closely related documents on this site. For more try a [subject or free text search](#)

[The primary prevention of hepatitis C among injecting drug users](#) REVIEW ABSTRACT 2009

[Female crack smokers respond well to standard HIV risk-reduction sessions](#) NUGGET 2004

[Hepatitis C and needle exchange part 4: the active ingredients](#) THEMATIC REVIEW 2004

[Needle and syringe programmes: providing people who inject drugs with injecting equipment](#) REVIEW ABSTRACT 2009

[Hepatitis C and needle exchange part 2: case studies](#) THEMATIC REVIEW 2003

[Hepatitis C and needle exchange](#) SERIES OF ARTICLES 2004

[Hepatitis C is spreading more rapidly than was thought](#) OFFCUT 2005

[Hepatitis C and needle exchange part 1: The dimensions of the challenge](#) THEMATIC REVIEW 2003

[Hepatitis C and needle exchange part 3: the British record](#) THEMATIC REVIEW 2004

[Change of gear needed if needle exchanges are to combat hepatitis infection](#) NUGGET 2001